PROVIDER AGREEMENT
Children's Special Health Care Services (CSHCS)
Maximum Caseload Addendum

State Form 51399 (7-03)
Indiana State Department of Health

I/We choose to accept no more than ____ active cases with the Children's Special Health Care Services Program, at this time.

Provider DBA Name _____

Officer Name _____ Title _____

Signature _____ Date _____

Telephone Number _____ ISDH Provider ID _____

Do not complete this form <u>unless</u> you wish to limit the number of patients you accept, which are participants in the Children's Special Health Care Services Program.